

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10180

CERTIFICATE OF DEATH

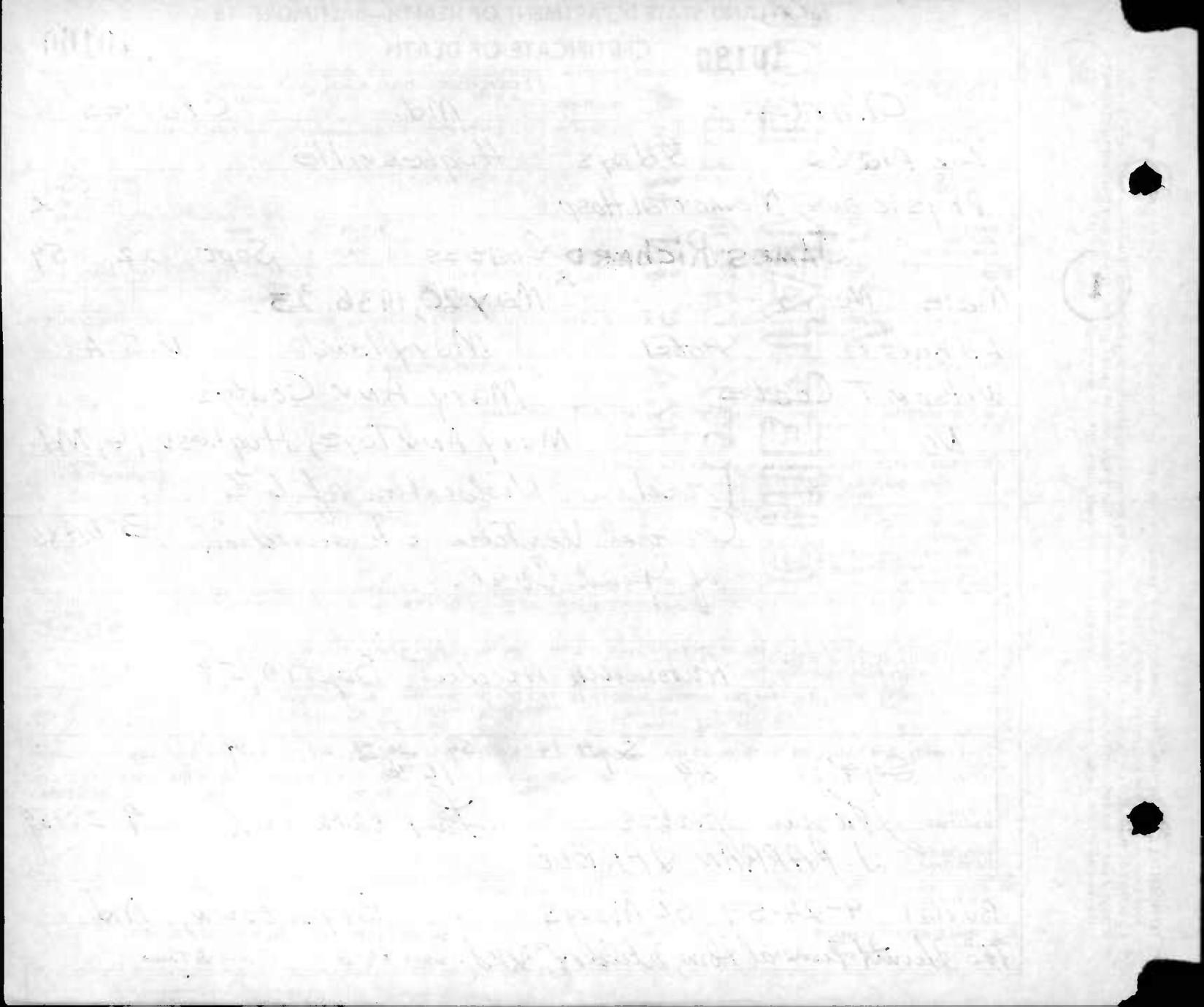
10160

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lan Plaza</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>JAMES</i>	Middle <i>RICHARD</i>	Last <i>Coates</i>
4. DATE OF DEATH <i>Sept 22, 1959</i>	Month Day Year	Month Day Year	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>May 20, 1936</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Wilson T. Coates</i>	14. MOTHER'S MAIDEN NAME <i>Mary Ann Coates</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. —	INFORMANT <i>Mary Ann Toye, Hughesville, Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture - Dislocation of 6th Cervical Vertebra & Transection of Spinal Cord.</i>			
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>823X</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Automobile Accident Sept 19/59 (Car off road)</i>	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>23 Church Road</i>	(County) <i>Charles</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Sept 19, 1959</i> to <i>Sept 21, 1959</i> that I last saw the deceased alive on <i>Sept 21, 1959</i> , and that death occurred at <i>10:36 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Parran Jarboe</i>	M.D.	ADDRESS (Street, city or town, state) <i>Lan Plaza, Md.</i>	DATE SIGNED <i>9-22-59</i>
PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-24-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St Marys</i>	22d. LOCATION (City, town, or county) (State) <i>Bryantown, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>VS A15 (4) 4/9/58</i>	24b. REGISTRAR'S SIGNATURE <i>C. Hunt & Son</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10161

Reg. Dist. No.

10181

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Za Plata</i>		c. LENGTH OF STAY IN 1b <i></i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy Marin Hosp</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47x-3</i>	
d. STREET ADDRESS <i>614 Orleans pl 98</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ROBERT MORRIS DIGGS</i>		4. DATE OF DEATH <i>SEPT. 29 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>April 5 1903</i>
8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
13. FATHER'S NAME <i>Issecca Johnson</i>		11. BIRTHPLACE (State or foreign country) <i>Washington DC USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		12. CITIZEN OF WHAT COUNTRY? <i></i>	
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Ernest Diggs</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured Liver</i> <i>823X and due to</i>		INTERVAL BETWEEN ONSET AND DEATH <i>46 h.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		b) <i>Bilateral Hemothorax</i> <i>46 h.</i>	
DUE TO <i></i>		c) <i>Multiple Rib Fractures</i> <i>46 h.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Secondary Hemorrhage</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Passenger - auto accident - Potomac River Bridge</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>12 noon 9-27 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> <i>RT. 301</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i>NEWBERG, CHARLES, MD.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>V.B. Dettor</i>		DATE SIGNED <i>9-29-59</i>	
EXAMINER'S NAME (Type) <i>V.B. DETTOR</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL OR CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-3-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Lincoln</i>		22d. LOCATION (City, town or county) (State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>V. D. Baker 1772 - 4576</i>		24a. REC'D BY REGISTRAR DATE OCT 2 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur St. Kraus</i>	

b.6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10182

CERTIFICATE OF DEATH

Reg. Dist. No.

10162

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY							
Bryantown		Life		X Bryantown		Charles							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
First		Middle		Last		4. DATE OF DEATH	Month Sept 26 1959						
3. NAME OF DECEASED (Type or print)		Elizabeth Gill Bowling Forbes Edelen				5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (last birthday) 84 yrs.)	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>		
F		W							May 17 1875	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
				Own Home		Maryland		U.S. A.					
13. FATHER'S NAME		George Foybes Edelen		14. MOTHER'S MAIDEN NAME		Frances Bowling							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		NO		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
				None		Edward G. Edelen, Bryantown, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis										12 Days			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension										20 Years			
(c) Generalized Arterio Sclerosis										20 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)				
21. I certify that I attended the deceased from SEPTEMBER, 1947, to SEPT. 26, 1959, that I last saw the deceased alive on SEPTEMBER 26, 1959, and that death occurred at 4:45 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		John H. Griffin M.D.								DATE SIGNED			
PHYSICIAN'S NAME (Type)		Box 65, Hughesville, Md. 9-27-59											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
Burial		9-30-59		St Mary's		Bryantown, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
The Smith Funeral Home, Hyattsville, Md.				DATE OCT 1 '59		OCT 1 '59							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10163

10183

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		M		CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		Md		Charles		Reg. Dist. No.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		La Plata		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Md		Charles					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Physicians Mem. Hospital		d. STREET ADDRESS		d. STREET ADDRESS		Indian Head		45 - Mattingley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		HENRY SMITH		First Middle Last		4. DATE OF DEATH		SEPT.		Month Day Year		14 1959			
5. SEX		Male White		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.			
						WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb 12 1875 84 yrs.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
						Bookkeeping Long Island N.Y.		USA							
13. FATHER'S NAME		John		14. MOTHER'S MAIDEN NAME											
						Elsebough Catherine Welch									
15. HAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		No		16. SOCIAL SECURITY NO.		INFORMANT		Address							
				080-09-9468		L Kiernan Indian Head.									
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation 15 min.															
434.4 DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic cardiac failure 6 months															
DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. ADDRESS (Street, city or town, state)		20h. DATE SIGNED	
				19								La Plata, Md.		9-14-57	
21. I certify that I attended the deceased from 9 14, 1957, to 9 14, 1957, that I last saw the deceased alive on 9 14, 1957, and that death occurred at 9 14, 1957, M, from the causes and on the date stated above.															
ACTUAL SIGNATURE		M. Johnson		M.D.											
PHYSICIAN'S NAME (Type)															
22a. FUNERAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)									
Burial		9/18/58		Evergreens		Long Island N.Y.									
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
Richard J. La Plata		Md		Sep 21 '59		Edna E. Thomas									

DEPARTMENT OF STATE - ALASKA
CERTIFICATE OF DEATH

1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G249 10/2/59 iwk

10184

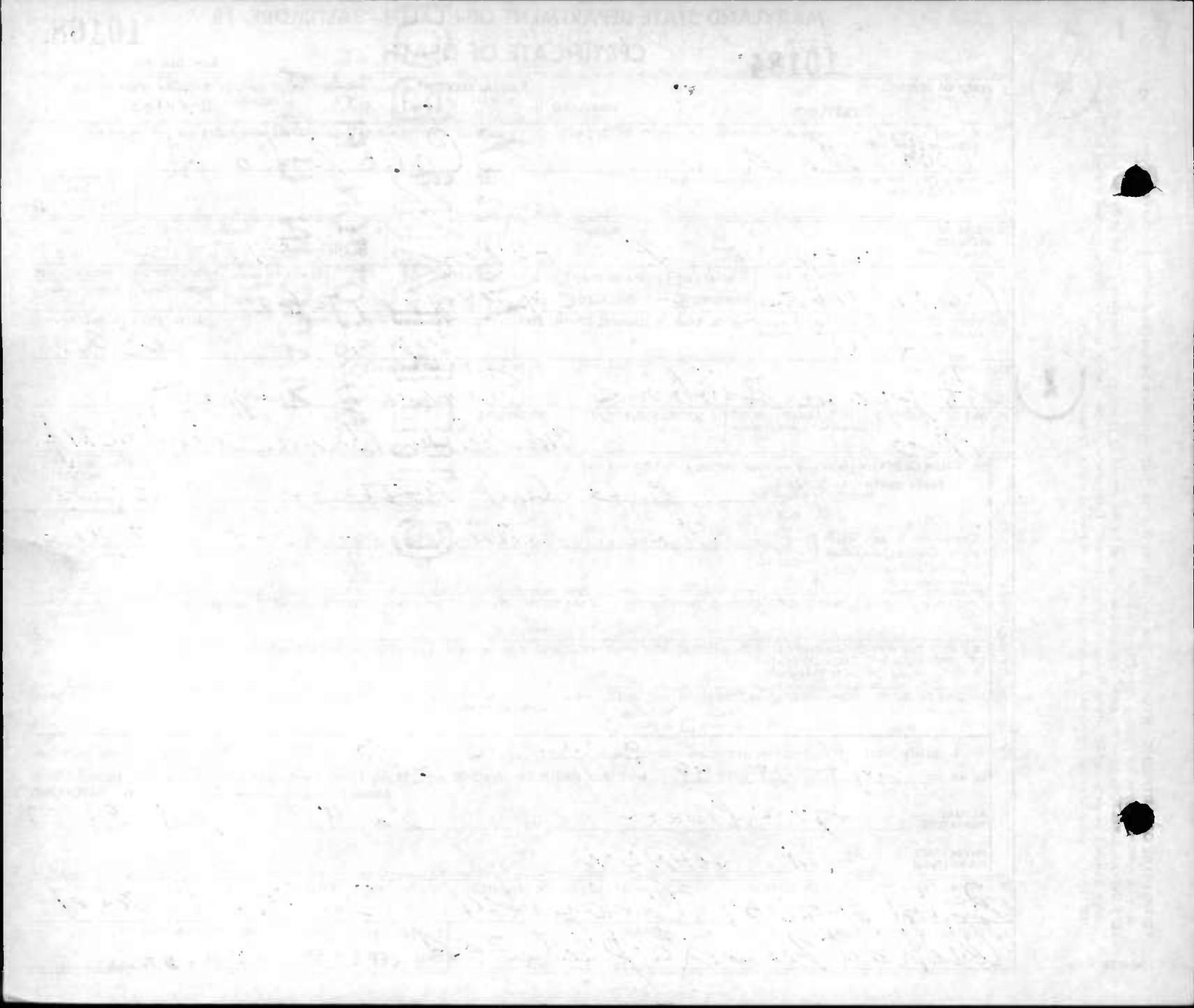
10168

Reg. Dist. No.

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION /		e. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) JEANNETTE		First B	Middle
4. DATE OF DEATH Month SEPT Day 24 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1887 72 yrs.
9. AGE (In years last birthday) 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14 W	11. KIND OF BUSINESS OR INDUSTRY /	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Niram Gibbons	14. MOTHER'S MAIDEN NAME Elizabeth Daugherty		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. /	INFORMANT Mr Ralph Blod, London N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 24 hr. 5 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) /	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) /	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) /	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>Sept 24</u> , 1957, that I last saw the deceased alive on <u>Sept 15, 1959</u> , and that death occurred at <u>10A M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Le Plata, Md 9-24-59 DATE SIGNED	
ACTUAL SIGNATURE F. M. Johnson	M.D.		
PHYSICIAN'S NAME (Type) F. M. JOHNSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9-26-59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Archibald Madala	ADDRESS Plaza Land	24a. REC'D BY REGISTRAR SEP 29 '59	24b. REGISTRAR'S SIGNATURE Arthur & Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10164

10185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) RUTH HALL		First	Middle	Last	4. DATE OF DEATH MALLORY	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH August 7, 1874	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Milford, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Bartell				14. MOTHER'S MAIDEN NAME Louisa M. La Gross				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. C.J.Gridley- La Plata , Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 693.4		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Rheumatoid arthritis allulitis of rt leg. bed aches		INTERVAL BETWEEN ONSET AND DEATH days		
DUE TO (c)						1 week 2 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured hip in middle of May - had nail mallet						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) fell down at home						
20c. TIME OF INJURY Hour o. m. my 1959 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or Town) La Plata		(County) Charles, Md. (State)
21. I certify that I attended the deceased from alive on <u>Sept 6</u> , 1959, and that death occurred at <u>La Plata, Md.</u>						ADDRESS (Street, city or town, state) La Plata, Md.		DATE SIGNED 9-7-59
ACTUAL SIGNATURE F.M. Johnson		M.D.						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/1959		22c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		22d. LOCATION (City, town, or county) Apache		(State) Oklahoma
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC.		ADDRESS La Plata, Maryland		24a. REC'D BY REGISTRAR DATE SEP 11 '59		24b. REGISTRAR'S SIGNATURE Arthur & Trans		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10165

10186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DAISY	Middle	Last McPHERSON
4. DATE OF DEATH	Month Sept	Day 26	Year 1959
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12 1902
9. AGE (in years last birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Maryland
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. FATHER'S NAME Frank McPherson	15. MOTHER'S MAIDEN NAME Elizabeth Norris	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? No	17. SOCIAL SECURITY NO. None	INFORMANT Katie Cager, La Plata, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cerebro vascular hemorrhage 3 days	
		Arteriosclerotic Hypertension 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1956 to Sept 1957, that I last saw the deceased alive on Sept 20, 1957, and that death occurred at 11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE FM Johnson		ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 9-28-57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-1-59	
22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart		22d. LOCATION (City, town, or county) La Plata, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The Bennett Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DAT OCT 2 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10166

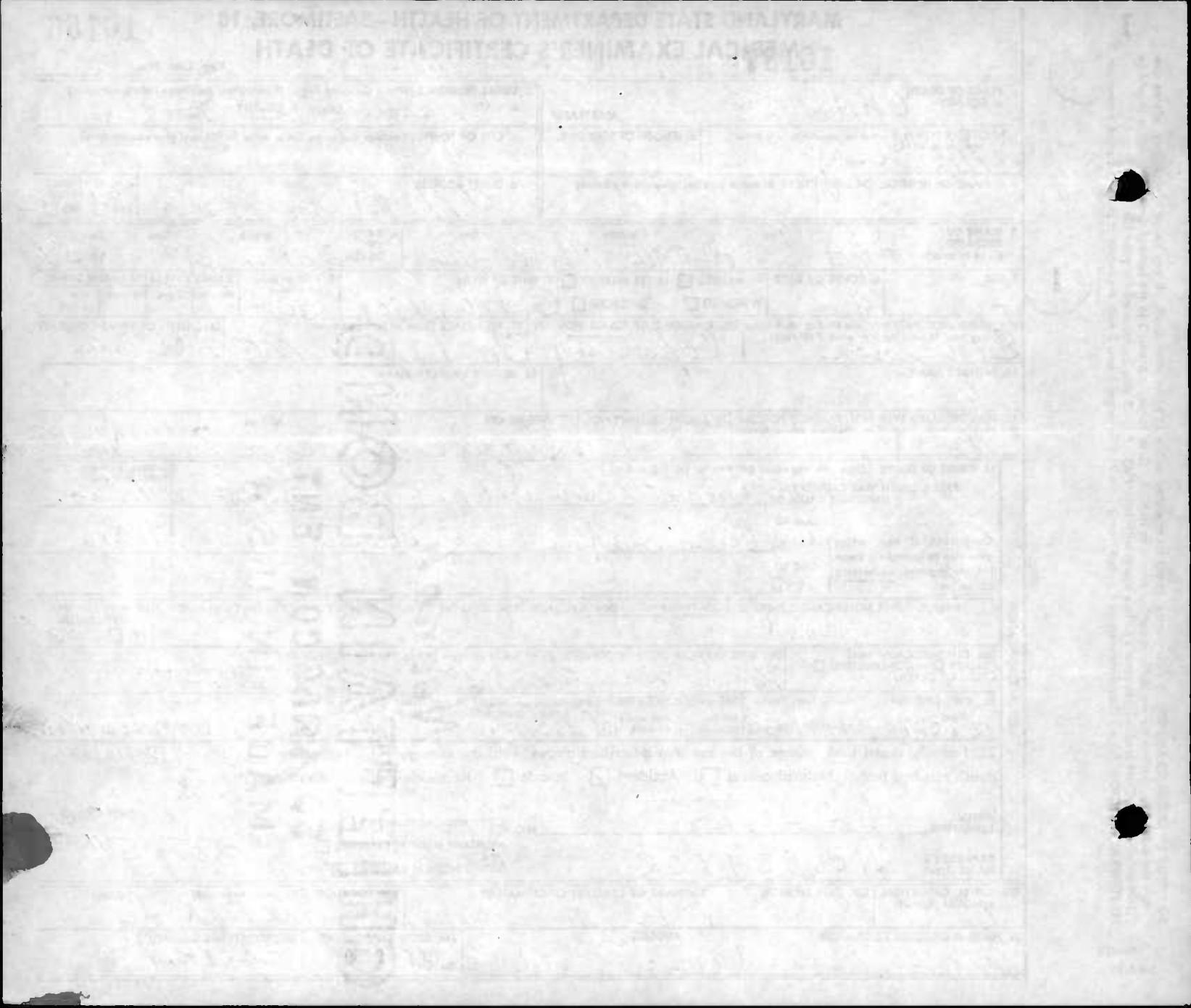
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Washington DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3	
d. STREET ADDRESS 911 Main St. N.W.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADA First VALERIE Middle MITCHELL Last		4. DATE OF DEATH SEPT. 27 Month Day Year 1959	
5. SEX F 6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept 10, 1909		9. AGE (in years lost birthday) 50 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Coffatery	
11. BIRTHPLACE (State or foreign country) Fayetteville NC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. Address	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Subarachnoid Hemorrhage 823X Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 hrs.	
and Crush Injuries of Chest (c)		7 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger auto accident - stuck shuttment	
20c. TIME OF INJURY Month, Day, Year Hour 12:00 P.M. 9-27-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> U.S. 301	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) NEWBURG, CHARLES, MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE V.B. Dettor		DATE SIGNED 9-27-59	
EXAMINER'S NAME (Type) V.B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-59	
22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn		22d. LOCATION (City, town, or county) Wash. D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. B. Board 1722 7th St. NW		ADDRESS	
		24a. REC'D BY REGISTRAR OCT 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur J. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10167

10188

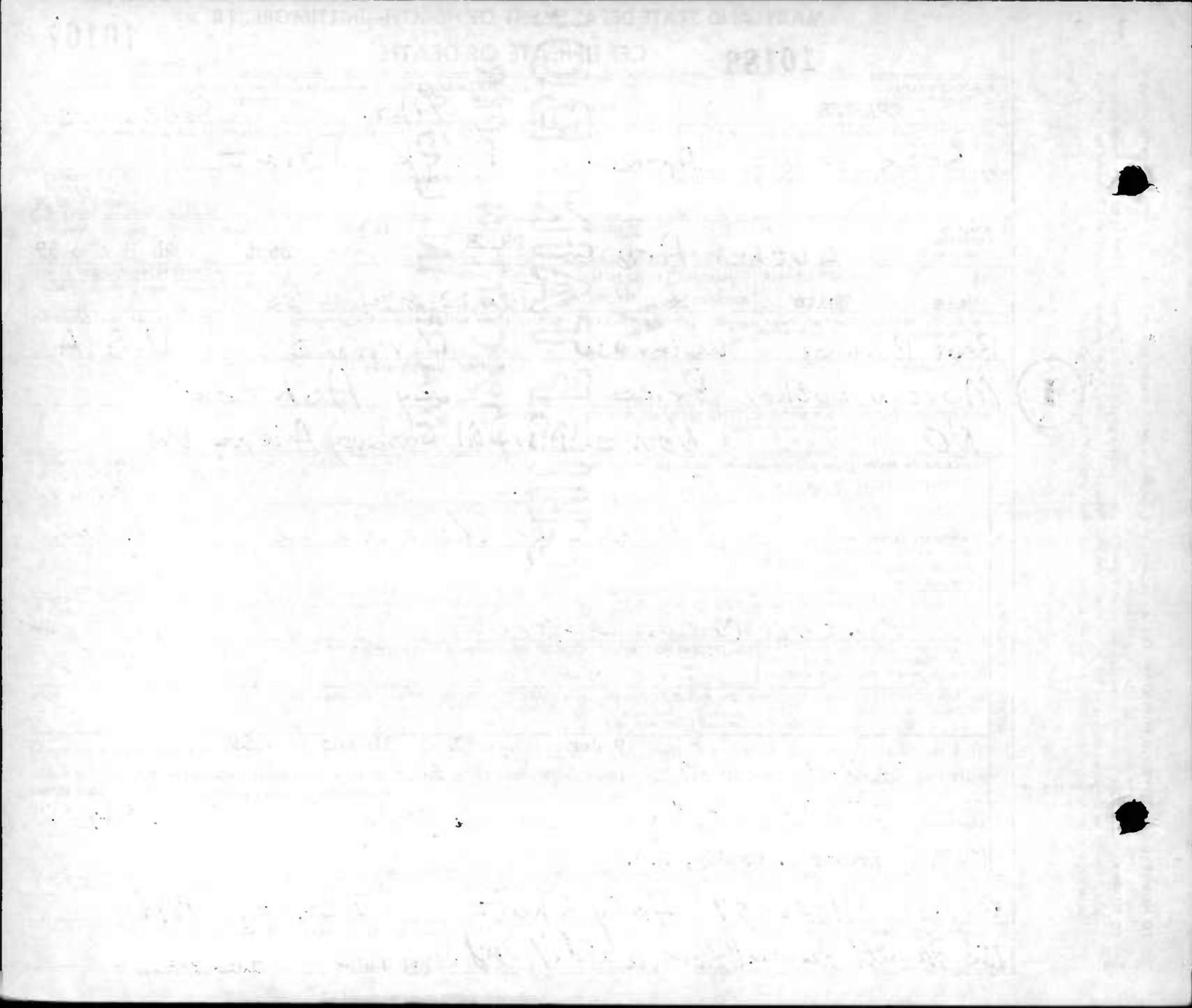
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Point		c. LENGTH OF STAY IN 1b Appr. 60 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Point	
e. STREET ADDRESS /		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Luther Arnold		First L	Middle U
4. DATE OF DEATH sept 24 1959		Last P	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 22 1874
9. AGE (In years lost birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Builder		10b. KIND OF BUSINESS OR INDUSTRY Waterman	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Luther Price		14. MOTHER'S MAIDEN NAME Lucy Ashton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mary M. Gonsano, Alex, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congr. occlusion (c) Arterosclerotic heart disease.			
INTERVAL BETWEEN ONSET AND DEATH minutes.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Basal cell carcinoma face.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Jan 1951 , to 10 Aug 1959 , that I last saw the deceased alive on 24 Sept 1959 , and that death occurred at 6: A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Wooldy		ADDRESS (Street, city or town, state) M.D. La Plata - Md.	
PHYSICIAN'S NAME (Type) Arthur O. Wooldy, M.D.		DATE SIGNED 25 Sept 59.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-59	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) Issue, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS Arthur & Kuhn	
24a. REC'D BY REGISTRAR SEP 30 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kuhn	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10189 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10169

1. PLACE OF DEATH a. COUNTY Charles				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN b. 20 min			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hosp.				e. STREET ADDRESS Pisgah			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) AGNES YVONNE PROCTOR		First	Middle	Last	4. DATE OF DEATH	Month	Day Year
5. SEX F		6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov 13 1937	9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George G. Gray		14. MOTHER'S MAIDEN NAME Annie Butler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-34-7045		17. INFORMANT John Proctor, Pisgah, Md.		Address	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Shock and hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 30 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 825X		Rupture of pregnant uterus		30 min.			
DUE TO (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - Route 301 and 6		20c. TIME OF INJURY Month, Day, Year Hour 9-15 1959		20d. INJURY OCCURRED While at work Not white at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) La Plata, Charles, Md.		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE V.B. Dettor		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-15-59			
EXAMINER'S NAME (Type) V.B. DETTOR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-59		22c. NAME OF CEMETERY OR CREMATORIAL St Catherine		22d. LOCATION (City, town, or county) Mc Conchig, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR Cards & Trans		24b. REGISTRAR'S SIGNATURE	
				DATE SEP 22 '59			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to: Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

18
FOR STATE
HEALTH DEPT.
H

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	LA PLATA		c. LENGTH OF STAY IN lb	NY NASSAU ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	PHYSICIAN'S MEMORIAL HOSPITAL		d. STREET ADDRESS	Seaford - Long Island	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
F	W.		Rosen	SEPTEMBER 15	1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-9-1914	45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Hawg.		—		Palond	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Osman		Becky Zepnick		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		yes - unknown		Benjamin Rosen - Seaford, L.I., N.Y.	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Shock and Hemorrhage 2 h. 45 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Crush injuries of chest 2 h. 45 m.			
DUE TO (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
Scleioderma					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 7:30 P.M. 9-15 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) LA PLATA	(County) CHARLES, MD. (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>V.B. Dettor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) V.B. DETTOR, M.D.		DATE SIGNED 9-15-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bethesda Cem. Washington DC	22d. LOCATION (City, town, or county) Long Island	(State) N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Bedzansky Sons		24a. REC'D BY REGISTRAR Arthur E. Kline		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	
3501 149 St NY		DATE SEP 16 '59			

W. BROWNSTEIN-HYMAN, D. COHEN, A. B. STAVIS, J. M. TAYLOR,
H. TAN, S. STACHELSKI, R. MAXWELL, K. L. Z.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10171

Item 8 Film G248 9-11-59 et

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Charles Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Rural Waldorf		Life		Waldorf-Rural				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
MALE		PHILLIP	Edward	SEMBLY	SEPTEMBER 1			1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
		NEGRO		1927 77 yrs.	Months Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer			Farming		Maryland		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
Richard Semby			Ella Browner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)	
							INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: none			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collapsed while walking to house		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour 9:30 a.m. 9-1 1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
					(City or town) (County) (State) Waldorf, Charles, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE V.B. Dettor		DATE SIGNED 9-1-59						
EXAMINER'S NAME (Type) V.B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-59		22c. NAME OF CEMETERY OR CREMATORIAL ST Marys		22d. LOCATION (City, town, or county) Bryantown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR Date 8 '59		24b. REGISTRAR'S SIGNATURE C. Mulligan & Sons		

DEATH - CERTIFICATE OF DEATH OR CERTIFICATE OF DEATH AND CAUSE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10191

CERTIFICATE OF DEATH

Reg. Dist. No.

10172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove suburban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Issue (Rural)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		d. STREET ADDRESS I		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) THOMAS		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1883	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Ross Swann		14. MOTHER'S MAIDEN NAME Cecelia Herbert						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Annie L. Swann (Wife), Issue, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		acute cardiac dilatation (or Pulmonary Emphysema (Pulmonary))				INTERVAL BETWEEN ONSET AND DEATH 10 min 5 years 10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on Sept 24, 1957, and that death occurred at 7:05 P.M., from the causes and on the date stated above.								
ACTUAL SIGNATURE F. J. Johnson		M.D.		ADDRESS (Street, city or town, state) 21 Plata, Md.		DATE SIGNED 9-24-59		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/1959		22c. NAME OF CEMETERY OR CREMATORIAL Holy Ghost Cemetery		22d. LOCATION (City, town, or county) Issue, Charles Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC., La Plata, Md.		ADDRESS La Plata, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hause		

REF ID: A6294

10101

10101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10192

CERTIFICATE OF DEATH

10173

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		c. LENGTH OF STAY IN 1b 7-Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		d. STREET ADDRESS 138-Circle Pts Indian Head Md		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Holly Jackson Whitman		First Evermont	Middle None	Last Whitman	4. DATE OF DEATH 9-19-59	Month 9	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-1887	9. AGE (In years lost birthday) yrs. 72	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Railroad		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Kentucky-District-West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Holly Jackson Whitman		14. MOTHER'S MAIDEN NAME (214-97-0106) Amanda Cottle						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 44-12-1234		17. INFORMANT Pauline Tedrick (Daughter)		Address Oxon Hill Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		DUE TO 420.1				INTERVAL BETWEEN ONSET AND DEATH 1-Hour		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis		DUE TO Indefinite						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland Md		20f. (City or town) Cumberland		(County) Md. (State) Md.
21. I certify that I attended the deceased from 9-1-58 , 19, to 9-19-59 , 19, that I last saw the deceased alive on 9-19-59 , 19, and that death occurred at 8:30P M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Cumberland Md		
ACTUAL SIGNATURE James E. Andrews						DATE SIGNED 9-19-59		
PHYSICIAN'S NAME (Type) James E. Andrews, Indian Head Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-59		22c. NAME OF CEMETERY OR CREMATORIUM Hell Crest		22d. LOCATION (City, town, or county) Cumberland Md (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Archant Inc La Plata Md		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thorne		

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